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### Medical Ear Piercing Consent Form

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

***Please initial each for consent:***

- ★ \_\_\_\_\_ I understand that fees for ear piercing will not be filed to my health insurance company. All payments for this service are due at the time of the visit.
- ★ \_\_\_\_\_ I understand that my child's ears will be pierced with pre-sterilized, single use earrings.
- ★ \_\_\_\_\_ I acknowledge that if my child is taking blood thinning medication, antibiotics, steroids, or antihistamines that ear piercing may carry a greater risk.
- ★ \_\_\_\_\_ I acknowledge that if my child is diabetic, immune-compromised, has high blood pressure, is pregnant, has epilepsy, has hemophilia or other bleeding disorders, or has a heart condition, that ear piercing may carry a greater risk.
- ★ \_\_\_\_\_ I understand that ear piercing is a minor surgical procedure with similar risks to stitches or abscess drainage. Despite all precautions that are taken by Star and Fox Pediatrics, and my proper following of aftercare, the potential for infection still exists. There is also the potential that one or more of the following complications may occur as a result of ear piercing: persistent redness, swelling, drainage, bleeding, embedded clasp, local infection, cellulitis, blood poisoning (septicemia), keloid scarring, cauliflower ear, pressure sore or traumatic injury. I will contact Star and Fox Pediatrics if any of the above complications occurs.
- ★ \_\_\_\_\_ I have read and understand the AFTERCARE instructions and have received my copy for my reference. Aftercare of piercing is the responsibility of the patient or parent once they leave the office.
- ★ \_\_\_\_\_ I have agreed to this ear piercing procedure and am fully aware of the potential risks and complications.

I have read and understand all of the items listed above and agree to the terms. If the patient is a minor, then the undersigned certifies to Star and Fox Pediatrics that the undersigned is a parent or legal guardian of the minor patient named above.

**Printed name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_